What you should know about...
Health insurance appeals

Kentuckians who are enrolled in health benefit plans have expanded appeal rights under insurance laws. You have the right to appeal an insurer's decision to deny access to a treatment, service, drug or device. **Note: These rights do not apply if you are covered by certain policies including Medicare supplements, student health plans connected with a university, and employer self-funded plans.**

What can you do if your health benefit plan refuses to cover a service? You have the right to appeal. For example, your physician prescribes a surgical procedure and your insurer refuses to pay for it. You can appeal the decision.

An appeal is a formal request that the decision be reviewed and reversed. There are two kinds of appeal:

- *Internal appeal.* Review of the denial by the insurance company.
- *External review.* Review of the denial by an independent review entity not associated with the insurer.

Who can initiate an appeal under the law? The covered person (a person covered by a health benefit plan) or a health-care provider or other person authorized to act on the covered person's behalf can request an appeal.

Information your insurer must provide

The letter or notice from the insurer must contain:

- ✓ A statement giving specific medical and scientific reasons for the denial or identifying the provision in the benefits schedule or exclusions that demonstrate that coverage is not available.
- ✓ The state of licensure, medical license number, and the title of the person making the decision.
- ✓ A description of other alternative benefits, services or supplies covered by the health benefit plan, if any.
- ✓ Instructions for initiating an internal appeal of the denial including at least whether the appeal has to be in writing, time limits, schedules for filing appeals, and the position and phone number of a contact person for further information.

How do you begin the appeal process? Read the letter or notice sent by the insurer to find out why your request was denied and what you need to do to appeal the decision. (The box above lists what must be included in a denial letter.) If you have questions, call the contact person listed in the letter. Have your policy, health insurance card and Social Security number in hand when you make the call. It will be helpful if you know the exact diagnosis and the treatment you need in medical terms.

Internal appeals

Here are two terms that you need to know when filing an appeal:

- *Coverage denial* – The insurer contends that a service, treatment, drug or device is not covered by the person's health benefit plan and sends the covered person a notice of coverage denial.
- *Adverse determination* – The insurer determines a service, treatment, drug or device is not "medically necessary or appropriate" and denies, reduces or terminates coverage of the service, treatment, drug or device. The covered person gets an adverse determination.

The process begins when the covered person receives an adverse determination ***or*** a notice of coverage denial; or the insurer fails to make a determination within a certain time; or the insurer fails to send a notice. Then:

1. An internal review by the insurer is requested by the covered person or an authorized person. He or she may ask that a specialist conduct the review.
2. Insurers or their representatives must make a decision within 30 days of receipt of the appeal request -- or within three days if it's an expedited (emergency) appeal -- and inform the covered person that:

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(a) Payment is approved or
(b) Payment is denied. The insurer must provide information on the reasons for this decision.

If the issue is *coverage denial* and an internal review by the insurance company has been completed, the covered person or the authorized person can ask for the following review by the state:

1. A written request for review is submitted to the Department of Insurance in Frankfort by the covered person or an authorized person.
2. The department will review the request, require the company to respond within five days, and make a determination that:

(a) The coverage in question is limited or excluded by the health plan

or

(b) The coverage *is not* limited or excluded and the company must pay for the service or allow the person to have an external review.

External review

When can you ask for an external review? If paying the medical bill yourself will cost you $100 or more, you can request an external review. The request can be made by you or someone acting on your behalf with your written permission. The request must be filed within 60 days of receiving the insurer's final denial letter. The steps are:

1. You or an authorized person submits a request for an external review to your insurer, and gives written consent for disclosure of medical records to the independent review entity (IRE).
2. If your insurer refuses to grant you an external review, you may file a complaint with the Kentucky Department of Insurance. (See contact information at the bottom of this page.) Within five days, the department will make a decision about whether you are entitled to an external review.
3. An independent review entity (IRE) will be assigned to conduct the external review in accordance with state insurance laws.
4. The insurer pays for the review. You will be billed by the IRE for a $25 filing fee . This fee can be waived if you can show that payment will cause financial hardship as defined in state guidelines. The fee will be refunded or waived if the IRE finds in your favor.
5. The IRE makes a determination in a timely manner:

- Expedited (emergency) external reviews must be completed within 24 hours, unless you or your representative and the insurer agree to a 24-hour extension.
- Nonexpedited (nonemergency) external reviews must be completed with 21 days, unless you or your representative and the insurer agree to a 14-day extension.

What happens next? If the IRE decides in your favor, the insurance company must pay for the service, treatment, drug or device. If the external review decision *is not* in your favor, you have a right to file a civil lawsuit.

What is an IRE?

An independent review entity (IRE) uses health-care professionals and insurance coverage specialists to review decisions and determine if a service is covered or is medically necessary and appropriate. An IRE must be certified by the Kentucky Department of Insurance to ensure that the entity is qualified and able to conduct external reviews in a timely matter.

Specific measures are taken to ensure that no conflict of interest exists and that an IRE is independent and free of any alliance with any of the parties involved.

The IRE must consider information submitted by the insurer, the covered person and the health-care provider plus any relevant medical research or findings.

Written complaints concerning an IRE's conduct of an external review may be submitted to the Department of Insurance.

PUBLIC PROTECTION AND REGULATION CABINET
PROTECT · REGULATE · EDUCATE

Kentucky Department of Insurance
P.O. Box 517, Frankfort, KY 40602-0517
Phone: 1-800-595-6053 TTY (deaf/hard-of-hearing): 1-800-462-2081
http://www.doi.state.ky.us/kentucky/

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The Department of Insurance does not discriminate on the basis of race, color, national origin, sex, age, religion or disability and provides, upon request, reasonable accommodation, including auxiliary aids and services necessary to afford a person with a disability an equal opportunity to participate in services, programs and activities.

Rev. July 2002